DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/06/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER WATERS OF NEW CASTLE THE MATERIA SUMMARY STATEMENT OF DEFICIENCIES DID PROVIDER NAME OF STATEMENT OF DEFICIENCIES DID PROVIDER NAME OF STATEMENT OF DEFICIENCIES DID PROVIDER SPLAN OF CORRECTION NOUIL DEFICIENCY WILST BE PRECEDED BY FULL PROVIDE SPLAN OF CORRECTION SHOULD BE PROVIDER SPLAN OF CORRECTION NOUIL DEFICIENCY CROSS REFERENCED TO THE PAPER PROVIDED NAME OF CORRECTION SHOULD BE PROVIDER SPLAN OF CORRECTION SHOULD BE PROVIDED SPLAN OF CRAST SPLAN OF CORRECTION SHOULD BE PROVIDED SPLAN OF C			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.